X2014-1679

PRINTED: 10/16/2014
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504011	A. BUILDING _____ B. WING _____	10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS STATE LICENSING SURVEY This state hospital licensing survey was conducted at Cascade Behavioral Hospital on 10/7/2014-10/9/2014 by Paul Kondrat, RN, MN, MHA and Alex Giel, REHS. ASE#:F6EL11	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLAN OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. Your Plan of Correction is due on October 30, 2014. 4. Return the original report with the required signatures.	
L 315	322-035.1C POLICIES-TREATMENT WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (c) Providing or arranging for the care and treatment of patients; This RULE: is not met as evidenced by: Based on observation, review of hospital policies and procedures, and interview, the hospital failed	L 315	Plan of Correction received 10/31/2014 Plan of Correction approved 11/7/2014 Paul M Kondrat RN, MN, MHA 11/13/2014	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Director, Quality & Risk — 10/30/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504011	A. BUILDING _____ B. WING _____	10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From Page 1 to implement procedures for allergy identification for 2 out of 2 patients observed (Patients #15, #16). Findings: 1. The hospital's policy and procedure titled "Color-Coded Patient Wristbands" (Approved 12/2013) read in part: "It is during the initial and reassessment procedures that risk factors associated with DNR (Do Not Resuscitate), allergies, and falls status are identified or modified. . . The following represents the meaning of each colored coded band: Red, Allergy Alert". 2. On 10/7/2014 at 1:30 PM, during a tour of the Adult Psychiatric Unit, Surveyor #1 observed a patient without a red allergy wrist band as required by hospital policy. Patient #15 has documented allergies to ceclor (an antibiotic), septra (an antibiotic), azithromycin (an antibiotic), ambien (a hypnotic) and lamictal (anti-epileptic medication) in the medical record. 3. On 10/7/2014 at 1:30 PM, during a tour of the Adult Psychiatric Unit, Surveyor #1 observed a patient without a red allergy wrist band as required by hospital policy. Patient #16 has a documented allergy to sulfa (a class of antibiotics) in the medical record. 4. On 10/7/2014 at 1:30 PM during an interview with Surveyor #1, the nurse manager (Staff Member #3) of the Adult Psychiatric Unit stated they did not put red allergy wrist bands on their patients with documented allergies and did not have any allergy bands on the unit.	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504011	A. BUILDING _____ B. WING _____	10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 410	Continued From Page 2	L 410		
L 410	322-035.1V POLICIES-FOOD SERVICE WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (v) Food service consistent with chapter 246-215 WAC and WAC 246-322-230. This RULE: Is not met as evidenced by: Based on observation, hospital staff failed to follow policies and procedures to assure compliance with the Washington State Retail Food Code (246-215 WAC). Findings: 1. On 10/7/2014 at 10:50 AM, Surveyor #2 tested the chlorine concentration levels in the sanitizer container located near the food prep station in the kitchen. Levels of chlorine tested were over 200 ppm which exceeds the parameters of concentration stated in the Washington State Retail Food Code. Concentration needs to be within 50-100 ppm. Reference: Section 0465 Equipment - Manual and mechanical warewashing equipment, chemical sanitization - Temperature, pH, concentration, and hardness (2009 FDA Food Code 4-501.114 2. On 10/7/2014 at 11:45 AM, Surveyor #2 observed a sandwich with an expiration date of 10/5 located in the refrigerator on the 2nd floor kitchen. This was discarded at the time of inspection. Reference: Washington State Retail Food Code, WAC 246-215-3700	L 410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504011	A. BUILDING _____ B. WING _____	10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 415	322-035.2 P&P-ANNUAL REVIEW WAC 246-322-035 Policies and Procedures. (2) The licensee shall review and update the policies and procedures annually or more often as needed. This RULE: is not met as evidenced by: Based on review of hospital policies and procedures, the facility failed to review the dietary manual on an annual basis. Findings: After reviewing polices and procedures on 10/8/2014, Surveyor #2 found that the policy titled, "Franciscan Health System Nutrition Care Manual - Diet Manual Policy No. NC 3110 last Date Revised 1/2012 Next Review Date 1/2015", is only reviewed every 3 years which does not meet Washington Administrative Code (WAC 246-322-035) for Psychiatric Hospitals.	L 415		
L 615	322-050.9A TB-MANTOUX TEST WAC 246-322-050 Staff. The licensee shall: (9) In addition to following WISHA requirements, protect patients from tuberculosis by requiring each staff person to have upon employment or starting service, and each year thereafter during the individual's association with the hospital: (a) A tuberculin skin test by the Mantoux method, unless the staff person: (i) Documents a previous positive Mantoux skin test, which is ten or more millimeters of induration read at forty-eight to seventy-two hours; (ii) Documents meeting the requirements of	L 615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504011	A. BUILDING _____ B. WING _____	10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 615	Continued From Page 4 this subsection within the six months preceding the date of employment; or (iii) Provides a written waiver from the department or authorized local health department stating the Mantoux skin test presents a hazard to the staff person's health; This RULE: is not met as evidenced by: Based on staff record review the facility failed to follow WISHA requirements that would protect patients from tuberculosis (TB) by requiring each staff member to be screened for TB upon employment or starting service. Findings: After record review on 10/8/2014, Surveyor #2 found that 5 out of 7 staff members were out of compliance with TB screening.	L 615		
L 780	322-120.1 SAFE ENVIRONMENT WAC 246-322-120 Physical Environment. The licensee shall: (1) Provide a safe and clean environment for patients, staff and visitors; This RULE: is not met as evidenced by: Based on observation, the facility failed to store toxic chemicals in a secured area. To prevent ingestion of toxic chemicals, all chemicals should be secured in a locked area. Findings: On 10/7/2014 at 11:45 AM, during a tour of the patient's kitchen on the 2nd floor(Chemcial Dependency Unit), Surveyor #2 observed sanitizer wipes left out on the kitchen counter. This kitchen	L 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504011	A. BUILDING _____ B. WING _____	10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 780	Continued From Page 5 is utilized by patients, staff and visitors. The product was removed by the quality manager (Staff Member #6) during the survey.	L 780		
L1055	322-170.2C EXAM & MEDICAL HISTORY WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (c) A physical examination and medical history completed and recorded by a physician, advanced registered nurse practitioner, or physician assistant within twenty-four hours following admission, unless the patient had a physical examination and medical history completed within fourteen days prior to admission, and the information is recorded in the clinical record; This RULE: Is not met as evidenced by: Based on record review and review of policies and procedures, the hospital failed to ensure that a history and physical exam was completed and placed into the medical record within 24 hours of admission for 4 of 22 records reviewed (Patients #4, #5, #6, and #7). Findings: 1. The hospital's policy and procedure titled "Assessment/Re-Assessment" (Approved 1/2014) read in part: "Within the first twenty-four (24) hours of the patient's admission, a physician will complete a history and physical based on requirements established in the Medical Staff	L1055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504011	A. BUILDING _____ B. WING _____	10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1055	Continued From Page 6 rules and regulations." 2. Per review of Patient #4's medical record, the patient was admitted on 5/1/2014. The review showed a history and physical exam placed into the record on 5/5/2014 (4 days after admission). 3. Per review of Patient #5's medical record, the patient was admitted on7/9/2014. The review showed a history and physical exam placed into the record on 7/11/2014 (2 days after admission). 4. Per review of Patient #6's medical record, the patient was admitted on 7/1/2014. The review showed a history and physical exam placed into the record on 8/7/2014 (37 days after admission). 5. Per review of Patient #7's medical record, the patient was admitted on 10/6/2014. The review showed a history and physical exam placed into the record on 10/8/2014 (2 days after admission).	L1055		
L1060	322-170.2D PSYCH EVALUATION WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (d) A psychiatric evaluation, including provisional diagnosis, completed and documented within seventy-two hours following admission; This RULE: Is not met as evidenced by: Based on record review and review of policies and procedures, the hospital failed to ensure that a psychiatric evaluation was completed and placed	L1060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504011	A. BUILDING _____ B. WING _____	10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1060	Continued From Page 7 Into the medical record within 72 hours of admission for 3 of 22 records reviewed (Patients #8, #9, and #10). Findings: 1. The hospital's policy and procedure titled "Assessment/Re-Assessment" (Approved 1/2014) read in part: "Within the first sixty (60) hours of the patient's admission, the practitioner will complete the Psychiatric Evaluation based on requirements established in the Medical Staff rules and regulations." 2. Per review of Patient #8's medical record, the patient was admitted on 5/1/2014. The review indicated that staff did not place the patient's psychiatric evaluation into the record until 5/5/2014 (4 days after admission). 3. Per review of Patient #9's medical record, the patient was admitted on 3/22/2014. The review indicated that staff did not place the patient's psychiatric evaluation into the record until 3/27/2014 (5 days after admission). 4. Per review of Patient #10's medical record, the patient was admitted on 4/16/2014. The review indicated that staff did not place the patient's psychiatric evaluation into the record until 4/20/2014 (4 days after admission).	L1060		
L1065	322-170.2E TREATMENT PLAN-COMPREHENS WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504011	A. BUILDING _____ B. WING _____	10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From Page 8 retained, including but not limited to: (e) A comprehensive treatment plan developed within seventy-two hours following admission: (i) Developed by a multi-disciplinary treatment team with input, when appropriate, by the patient, family, and other agencies; (ii) Reviewed and modified by a mental health professional as indicated by the patient's clinical condition; (iii) Interpreted to staff, patient, and, when possible and appropriate, to family; and (iv) Implemented by persons designated in the plan; This RULE: is not met as evidenced by: Based on record review and review of policies and procedures, the hospital failed to ensure that a comprehensive treatment plan was developed within 72 hours of admission for 8 of 22 records reviewed (Patient #2, #3, #4, #11, #12, #13, and #14). Findings: 1. The hospital's policy and procedure titled "Treatment Planning" (Revised 2/2014) read in part: "Within 72 hours of admission, members of the treatment team shall develop the Interdisciplinary Treatment Plan that is based on a comprehensive assessment of the patient's presenting problems, physical health, emotional and behavioral status." 2. Per review of Patient #2's medical record, the patient was admitted on 4/1/2014. The review indicated that hospital staff placed the Interdisciplinary treatment plan into the record on 4/11/2014 (10 days after admission).	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504011	A. BUILDING _____ B. WING _____	10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From Page 9 3. Per review of Patient #3's medical record, the patient was admitted on 3/22/2014. The review indicated that hospital staff placed the interdisciplinary treatment plan into the record on 3/27/2014 (5 days after admission). 4. Per review of Patient #4's medical record, the patient was admitted on 5/1/2014 and discharged on 5/6/2014. The review did not show evidence that hospital staff included an interdisciplinary treatment plan in the patient record. Patient #4 was re-admitted to the facility on 5/9/2014, but hospital staff did not enter an interdisciplinary treatment plan into the record until 5/13/2014 (4 days after admission). 5. Per review of Patient #11's medical record, the patient was admitted on 4/22/2014. The review indicated that hospital staff placed an interdisciplinary treatment plan in the record on 5/4/2014 (12 days after admission). 6. Per review of Patient #12's medical record, the patient was admitted on 5/7/2014. The review indicated that hospital staff placed an interdisciplinary treatment plan into the record on 5/12/2014 (5 days after admission). 7. Per review of Patient #13's medical record, the patient was admitted on 5/14/2014. The review indicated that hospital staff placed an interdisciplinary treatment plan into the record on 5/19/2014 (5 days after admission). 8. Per review of Patient #14's medical record, the patient was admitted on 2/12/2014. The review indicated that hospital staff placed an interdisciplinary treatment plan into the record on 2/19/2014 (7 days after admission).	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504011	A. BUILDING _____ B. WING _____	10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1165	Continued From Page 10	L1165		
L1165	322-180.2 EMERGENCY SUPPLIES WAC 246-322-180 *Patient Safety and* Seclusion Care. (2) The licensee shall provide adequate emergency supplies and equipment, including airways, bag resuscitators, intravenous fluids, oxygen, sterile supplies, and other equipment identified in the policies and procedures, easily accessible to patient-care staff. This RULE: is not met as evidenced by: Based on observation, review of policies and procedures, and interview, the hospital failed to ensure adequate emergency supplies were accessible to patient care staff. Findings: 1. The hospital's policy and procedure titled Use and Care of Emergency Carts" (Approved 12/2013) read in part: "Emergency carts will be checked: 1. Every 24 hours on all patient care areas. . . .Check for availability of equipment against inventory list." 2. During the survey, Surveyor #1 found the following: a. On 10/7/2014 at 10:05 AM during inspection of the Chemical Dependency Unit, an unlocked emergency cart without intravenous fluids and associated sterile intravenous catheters. b. On 10/7/2014 at 1:30 PM during inspection of the Adult Psychiatric Unit, an unlocked emergency cart without intravenous fluids. c. On 10/9/2014 at 1:00 PM during inspection of	L1165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504011	A. BUILDING _____ B. WING _____	10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1165	Continued From Page 11 the Geriatric Psychiatric Unit, an unlocked emergency cart without intravenous fluids. 3. During an interview on 10/7/2014 at 2:00 PM with Surveyor #1, the interim director of nursing (Staff Member #2) stated the emergency carts policy was outdated and did not reflect the current procedures in place for emergencies. S/he acknowledged there was not a current inventory list for required equipment and supplies on the emergency cart.	L1165		
L1245	322-200.3B RECORDS-ASSESSMENT WAC 246-322-200 Clinical Records. (3) The licensee shall ensure prompt entry and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (b) Assessment and diagnostic data including history of findings and treatment provided for the psychiatric condition for which the patient is treated in the hospital; This RULE: is not met as evidenced by: Based on observation and interview, the hospital failed to follow its procedure for recording vital signs. Findings: 1. The hospital's policy and procedure titled "Vital Signs, Weights, I &O" (Approved 12/2013) read in part: "Vital signs will be monitored by the RN, and recorded in the patient's medical record." The hospital's policy and procedure titled "CIWA" (Approved 12/2013) read in part: "Document vital	L1245		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504011	A. BUILDING _____ B. WING _____	10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1245	Continued From Page 12 signs, I & O, CIWA (Clinical Institute Withdrawal Assessment) score, and doses of medication in the medical record. Vital signs should be documented on the nursing flow sheet." 2. During an observation of a medication pass on 10/7/2014 at 10:30 AM in the Chemical Dependency Unit, Surveyor #1 observed a registered nurse (Staff Member #4) check his/her "charge nurse sheet" for current vital signs of Patient #1 instead of the medical record. 3. During an interview immediately following the observation, Staff Member #4 stated that the certified nursing assistant (CNA) records the vital signs on the charge nurse sheet and the registered nurse then records them on the CIWA assessment sheet. Surveyor #1 then asked Staff Member #4 at what time does the CNA take vital signs on the patient? The registered nurse stated it was always between 9 and 10 AM on the day shift. During review of Patient #1's CIWA assessment sheet, the surveyor observed that the vital signs were annotated at 10:30 AM. 4. On 10/7/2014 at 11:00 AM during an interview with Surveyor #1, the interim director of nursing acknowledged the other two nursing units in the facility had a different process for recording vital signs.	L1245		
L1305	322-200.4A RECORDS-DATE WAC 246-322-200 Clinical Records. (4) The licensee shall ensure each entry includes: (a) Date; This RULE: is not met as evidenced by: Based on record review and review of hospital policies and procedures, the hospital failed to	L1305		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504011	A. BUILDING _____ B. WING _____	10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1305	Continued From Page 13 ensure that medical records contained date entries for 4 of 21 records reviewed for entries (Patient #1 and #2). Findings: 1. The hospital's "Rules and Regulations of the Medical Staff" (Approved 12/1/2013) read as follows: "All entries to the medical record must be legibly written, dated, timed and authenticated." 2. Per record review, Patient #1 was a 31 year old admitted on 10/3/2014 with a provisional diagnosis of alcohol detoxification. An inpatient detoxification admission order set did not have the date the physician assistant (Staff Member #1) signed page one of the protocol. 3. Per record review, Patient #1 was a 31 year old admitted on 10/3/2014 with provisional diagnosis of alcohol detoxification. An inpatient detoxification admission order set did not have the date the physician assistant (Staff Member #1) signed page two of the protocol. 4. Per record review, Patient #1 was a 31 year old admitted on 10/3/2014 with provisional diagnosis of alcohol detoxification. A nicotine withdrawal order set did not have the date the physician assistant (Staff Member #1) signed the protocol. 5. Per record review, Patient #2 was a 37 year old admitted on 4/1/2014 for alcohol dependence and anxiety related disorder. A discharge instruction sheet was noted to be complete except the RN/Signature line was blank for the date signed.	L1305		
L1310	322-200.4B RECORDS-TIME OF DAY WAC 246-322-200 Clinical Records. (4)	L1310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504011	A. BUILDING _____ B. WING _____	10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1310	Continued From Page 14 The licensee shall ensure each entry includes: (b) Time of day; This RULE: is not met as evidenced by: Based on record review and review of hospital policies and procedures, the hospital failed to ensure that medical records contained time entries for 5 of 21 records reviewed for entries (Patient #1 and #2). Findings: 1. The hospital's "Rules and Regulations of the Medical Staff" (Approved 12/1/2013) read as follows: "All entries to the medical record must be legibly written, dated, timed and authenticated." 2. Per record review, Patient #1 was a 31 year old admitted on 10/3/2014 with a provisional diagnosis of alcohol detoxification. An inpatient detoxification admission order set did not have the time the physician assistant (Staff Member #1) signed page one of the protocol. 3. Per record review, Patient #1 was a 31 year old admitted on 10/3/2014 with provisional diagnosis of alcohol detoxification. An inpatient detoxification admission order set did not have the time the physician assistant (Staff Member #1) signed page two of the protocol. 4. Per record review, Patient #1 was a 31 year old admitted on 10/3/2014 with provisional diagnosis of alcohol detoxification. A nicotine withdrawal order set did not have the time the physician assistant (Staff Member #1) signed the protocol. 5. Per record review, Patient #2 was a 37 year old admitted on 4/1/2014 for alcohol dependence and anxiety related disorder. A discharge instruction sheet was noted to be complete except the	L1310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504011	A. BUILDING _____ B. WING _____	10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1310	Continued From Page 15 RN/Signature line was blank for the time signed. 6. Per record review, Patient #3 was a 41 year old admitted on 3/8/2014 for alcohol dependence. An admission nursing assessment form was noted to be complete except the RN/Signature line was blank for the time signed.	L1310		
L1395	322-210.3G PROCEDURES-USE OF MEDS WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (g) Use of medications and drugs owned by the patient but not dispensed by the hospital pharmacy, including: (i) Specific written orders; (ii) Identification and administration of drug; (iii) Handling, storage and control; (iv) Disposition; and (v) Pharmacist and physician inspection and approval prior to patient use to ensure proper identification, lack of deterioration, and consistency with current medication profile; This RULE: is not met as evidenced by: Based on observation, review of policies and procedure, and interview, the hospital failed to follow its policy and procedure for use of medications owned by the patient. Findings: 1. The hospital's policy and procedure titled "Medication Management" (Approved 2/2014)	L1395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504011	A. BUILDING _____ B. WING _____	10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1395	Continued From Page 16 *read in part: "To ensure proper dispensing and* administration, all medications brought in by patients will be examined by the Pharmacist for identification and labeling . . . The pharmacist will label the medication as 'home med' as proof of checking . . .all (other) medications are placed in a tamper resistant sealed bag." 2. On 10/7/2014 at 1:30 PM in the Adult Psychiatric Unit medication room, Surveyor #1 observed in Patient #17's unit dose drawer the following unverified home medications: one bottle of Sinemet 100-25 tablets and one bottle of lorazepam 0.5mg tablets. 3. On 10/8/2014 at 9:50 AM in the Geriatric Psychiatric Unit mediation room, Surveyor #1 observed the following unverified home medications: in Patient #18's unit dose drawer, one bottle of valproic 250mg capsules; in Patient #19's unit dose drawer, one bottle of sinemet 25/250mg tablets, one bottle of meloxicam 7.5mg tablets, one bottle of ketoconazole shampoo and in Patient #20's unit dose drawer, one bottle of hydrochlorothiazide 25mg tablets, one bottle of lorsartan 50mg tablets, and one bottle of protonix 40mg tablets. In addition, Surveyor #1 found several bags of patient's home medications in non-tamper resistant bags. 4. During an interview immediately following the observation, the nurse manager (Staff Member #5) acknowledged the unverified home medications should be separated from the hospital issued unit dose medications.	L1395		